

Micki Ly, MD – Dermatologist rev. 11/07  
89 Hookele St. Suite 101  
Kahului, HI. 96732  
PH: (808) 877-6526 Fax: (808) 877-7033

I, \_\_\_\_\_, hereby authorize Micki Ly MD to disclose my health information,  
(Name of patient)

Including copies of medical records to (circle one):

- a) Any health insurance plan or company that provides coverage for me for the purpose of payment of charges.
- b) Any insurance company that provides liability insurance coverage for Dr. \_\_\_\_\_ for the purpose of evaluating the treatment or health care rendered to me.
- c) To Dr \_\_\_\_\_ Fax # \_\_\_\_\_  
Mailing address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

for continued health care.

- This authorization shall cover the period of time from my first visit to my last visit or from \_\_\_\_\_ to \_\_\_\_\_.
- I understand that I can revoke this authorization at any time.
- This authorization shall end two years after the day of my last visit. I understand that this authorization may allow the recipient of my health information to pass it onto others, so it may no longer be protected under federal law.

**PUPOSE OF DISCLOSURE (check all that apply):**

- Changing Physician       Continuing Health Care, appointment date: \_\_\_\_\_.
- School       Insurance       Legal       Workers Compensation       Consultation/Second Opinion
- Other (specify): \_\_\_\_\_.

Signed \_\_\_\_\_  
(Name of patient)

Date signed: \_\_\_\_\_

Printed name of patient: \_\_\_\_\_

IF the form is not signed in person and witnessed in our office, then this form is only good with official notarized signature:

Notary's signature and Stamp:

Date \_\_\_\_\_

County of: \_\_\_\_\_ State of \_\_\_\_\_

*\* Personal request for records fee: \$15.60 plus tax totaling \$16.25 per chart request, for the first 20 pgs, and \$0.42 per page there after. **\$16.25 is an upfront payment** and records cannot be copied until receipt of the prepayment. Postage is an additional charge. Costs are subject to change without notice. Please make checks payable to:*

Micki Ly, MD – Dermatologist  
P.O Box 668  
Puunene, HI 96784-0668

Any request for records will take 5 to 7 working days after the receipt of authorization and / or prepayment.